

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 006218	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/20/2012
NAME OF PROVIDER OR SUPPLIER KINDRED HOSPITAL- INDIANAPOLIS SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 607 S GREENWOOD SPRINGS DR GREENWOOD, IN 46143		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 30405 Facility Number: 006218</p> <p>Type of Survey: State Licensure Off Site JCAHO Accreditation Survey</p> <p>Date of JCAHO On Site Survey - Hospital full survey January 18-20, 2012</p> <p>Date of ISDH off site review - June 20, 2012</p> <p>Reviewer/Surveyor - Deborah Franco RN, PHNS</p> <p>Based on review of the January 18-20, 2011 JCAHO Accreditation Survey Report, it has been determined that Kindred Hospital Indianapolis South meets the requirements for Hospital Licensure in Indiana.</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1